

Institute of Public Care

Community Building - Literature Review

June 2010

Institute of Public Care

Community Building - Literature Review

1 Introduction

This paper was developed for Oxfordshire County Council by the Institute of Public Care at Brookes University. It focuses on recent UK material that can identify an evidenced based process to develop strong communities that can have a health/social care impact. IPC were asked within the review to:

- Look at sites where information is both costed and uncosted;
- Give a rough estimation of the quality of the analysis, identify key sources and arguments, review the strength of the evidence
- Come up with a series of potential 'best buys'.

2 Methodology

IPC considered more than forty articles, studies and reviews. These included:

- Literature reviews on low intensity support services, health improvement, community involvement in area-based initiatives, Older People Accessing Information and ICTs, Community Informatics, Communities, Social Capital and Public Policy, Public Value and Local Communities, Preventative Social Care
- Government documents
- Specific project evaluations
- Sociological / anthropological accounts of strong communities
- Major programme evaluations, such as the National Evaluation of Partnerships for Older People Projects, and the LinkAge Plus national evaluation

The report is divided into 4 sections:

- Definitions of a strong community – what the literature tells us
- The potential contribution that a strong community might make to health and well being
- Some community initiatives which are replicable, and which could make a contribution to these ends.
- Suggested ways forward.

3 Definitions of a strong community

Definitions of 'strong community' are often presumed rather than made explicit in the literature. A strong community can be anything that you want it to be, and the literature is full of different 'takes' on an old subject. There are also a plethora of concepts that are used instead of 'strong community' - terms like community capacity¹, and social capital² - and these more often attract formal definitions than 'strong community' itself.

Where the notion of 'strong community' is employed by government it is frequently linked to perceived 'ills' that call for a strong response - crime and anti-social behaviour, immigration, the benefits system, race relations and so on³. Like Russian dolls, each term has layers of features, characteristics and outputs, and these terms and features overlap in a sometimes ambiguous way.

Most of the literature reviewed is either from the policy arena - such as government policies, setting out ambitions for a strong community; or from the world of sociology / anthropology, describing how place 'x' was a strong community with characteristics a, b, & c which happened to help it achieve impacts d, e, & f for its citizens. There are relatively few robust evaluations of interventions planned to put in place some aspects or other of a strong community. There is even less information about cost effectiveness.

"The community approach has sought to measure communities in terms of their 'strength', but what constitutes strength in this context is far from clear. Strength can mean the capacity to act, or to maintain and enhance outcomes, to withstand shocks and support community members, but can also refer to values such as collaboration and participation, trust and responsibility. In policy making, social capital has become shorthand for community strength, even though it is more about associations and their density. This too had been hard to measure"⁴.

However, Blaug et al go on to observe that in its UK Social Capital Measurement Framework, the government has attempted to ensure that there is some consistency in this area by describing five key dimensions each with specific indicators – social participation, civic participation, social networks and support, reciprocity and trust, and the views of people in the local area.

¹ Community Capacity is defined as the capacity of the people in communities to participate in actions based on community interests, both as individuals and through groups, organisations and networks 'Communities – healthy, strong and prosperous: the links between the personalisation and place-shaping agendas in adult social care and health' IDEa 2008

² Social capital – defined by Sobel (among many) as "circumstances in which individuals can use membership in groups and networks to secure benefits" J, Sobel. Can we trust social capital?, Journal of Economic Literature, 40, 139-54, 2002

³ For example - Strong and Prosperous Communities, The Local Government White Paper, Communities and Local Government, 2006

⁴ Blaug, R et al. Public Value and Local Communities - a literature review, The Work Foundation , 2006.

Table 3: UK Social Capital Measurement Framework

Dimension	Examples of indicators
Social participation	<ul style="list-style-type: none"> • Number of cultural, leisure, social groups belonged to, and frequency and intensity of involvement • Volunteering frequency and intensity of involvement • Religious activity
Civic participation	<ul style="list-style-type: none"> • Perceptions of ability to influence events • How well informed about local/national affairs • Contact with public officials or political representatives • Involvement with local action groups • Propensity to vote
Social networks and social support	<ul style="list-style-type: none"> • Frequency of seeing/speaking to relatives/friends/neighbours • Extent of virtual networks and frequency of contact • Number of close friends/relatives who live nearby • Exchange of help • Perceived control of and satisfaction with life
Reciprocity and trust	<ul style="list-style-type: none"> • Trust in other people who are like you • Trust in other people who are not like you • Confidence in institutions at different levels • Doing favours and vice versa • Perception of shared values
Views of the local area	<ul style="list-style-type: none"> • Views on physical environment • Facilities in the area • Enjoyment of living in the area • Fear of crime

Although the practical importance of social capital is widely acknowledged as the 'glue' that helps hold people together, there is a tendency to discuss it at a theoretical rather than a practical level⁵. Camden, as a local authority, has engaged in work over the last decade to define key elements of social capital in that London borough. This has been underpinned by three local surveys. The Camden approach has been diagrammatically represented as follows:



⁵ Cummins, J and Miller, C. Co-production and social capital The role that users and citizens play in improving local services OPM briefing paper, October 2007

Different types of social capital can be described in terms of different types of networks:

- **Bonding social capital** describes closer connections between people and is characterised by strong bonds, e.g. among family members or close friends – it is good for 'getting by' in life. This is particularly important in the promotion of good health.
- **Bridging social capital** describes more distant connections between people and is characterised by weaker but more cross-cutting ties, e.g. with business associates, acquaintances, friends of friends – it is good for 'getting ahead' in life
- **Linking social capital** describes connections with people in positions of power and is characterised by relations between those in a hierarchy where there are differing levels of power – it is good for accessing support from formal institutions.⁶

Based on work by the Community Development Foundation it is possible to offer the following composite definition of a strong community:

"A Strong Community is one that people feel part of, and where they feel they have influence over decisions that affect them. It is able to identify its strengths and vulnerabilities and to use its capacity to maintain and enhance outcomes, to withstand shocks, and support community members."⁷

There is also a list of features that might characteristically be associated with a 'Strong Community':

- Citizenship, Participation and Engagement⁸
- Empowerment
- Associational activity
- Supporting networks and Neighbourliness
- Volunteerism and Altruism
- Reciprocity
- Collective norms and values
- Belonging
- Trust
- Safety
- Good information flows

⁶ See 4 op cit

⁷ Derived from Walker, A & Coulthard, M. Developing and understanding indicators of social capital, Social capital for health: issues of definition, measurement and links to health, NHS Health Development Agency, March 2004

⁸ Rogers, B & Robinson, E. The Benefits of Community Engagement: A review of the evidence, IPPR, Home Office, 2004- define community engagement as – 'the opportunity, capacity and willingness of individuals to work together to shape public life'

In health and social care terms it might also be desired to add in further descriptors on the lines of...

- A community that prevents...
- A community that re-ables....
- A community that supports non-institutional solutions..... and so on

The central theme is that these various characteristics generate positive effects on life chances. Hence different networks will lead, say, to different health effect pathways, or access to different forms of social capital and coping resources. Social exclusion may reduce capacity to access capital, and vice versa⁹. All kinds of positive impacts are seen to flow from strong communities, including:

- A reduction in crime through, for example, informal social monitoring and control¹⁰;
- Better resource targeting¹¹
- More relevant policy¹²;
- More sustainable solutions¹³.
- Enhanced social cohesion¹⁴
- Added economic value (through mobilisation of voluntary contribution and skill development with implications for job opportunities and community wealth)¹⁵.
- Safety, belonging, protection; mutual support and help; happiness – the more people speak to neighbours the happier they tend to be according to MORI; improved life chances, access to jobs.

*"Community engagement has the potential to improve the quality of the service supplied, but it can also improve the opportunities and capacities of those who rely on services, so lessening their need for them"*¹⁶

*"Where members of a community enjoy high levels of trust, benefit from good dispersion of information and share effective norms, they are able to attain ends which would otherwise be prohibitively costly (perhaps even impossible)"*¹⁷

However, it is not clear from the literature how much weight should be given to each element. That must be a matter for local, contextual judgement.

⁹ Johnson, D, Headey, B, & Jensen, B. Communities, Social Capital and Public Policy: Literature Review, Melbourne Institute Working Paper No. 26/03, Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, 2003

¹⁰ 4 op cit

¹¹ 4 op cit

¹² Active Partners Benchmarking Community Participation in Regeneration Yorkshire and Humber RDA

¹³ 5 op cit

¹⁴ 5 op cit

¹⁵ 5 op cit

¹⁶ Rogers and Robinson (2004) vii op cit.

¹⁷ King, D & Wickham-Jones, M. Social Capital, British Social Democracy and New Labour Democratisation, vol 6;4, 1999 referred to in 'In Search of Social Capital' G Johnston & J Percy-Smith 2003 Policy and Politics vol 31 3

4 The potential contribution that a strong community might make to health and well being

Specific impacts for social care and health that might flow from stronger communities are set out below:

- People who lack social networks are more likely to die from all causes than people with close family, friendship, and community ties.¹⁸.
- A sense of community can, on the other hand, boost immune systems, lower blood pressure, guard against ageing¹⁹.
- Social connections inhibit depression, low esteem, problems with eating and sleeping²⁰.
- Strong communities can relieve carers from some of burden of caring for elderly/sick people²¹.
- Joining a community group (if at present you belong to none) reduces your risk of dying in the next year by about the same amount as giving up smoking (and might be easier to do), but visiting friends or talking with them on the phone would be equally good²².
- The sense of empowerment that comes from managing your own long term health condition can result in less demand on NHS services, reduced symptom severity, significant pain decrease, improved life control/activity, improved resourcefulness and life satisfaction²³.
- Volunteering can reduce depression²⁴

'Communities and individuals that are engaged in identifying and solving their own health care needs are able to overcome any sense of powerlessness at the same time as generating healthy outcomes for themselves. The social capital

¹⁸ Putnam, R. Bowling Alone: The Collapse and revival of American Community, 2000 referred to in 7 op cit

¹⁹ Berkman, L .The Changing and Heterogeneous Nature of Ageing and Longevity: A Social and Medical Perspective, 1988 referred to in (7)op cit

²⁰ Neighbouring in contemporary Britain JRT 2006

²¹ See vii op cit

²² Berkman and Syme, 1979 'Social Networks, Host Resistance and Mortality: A Nine Year Follow-up of Alameda County Residents', American Journal of Epidemiology 109: 186-204.; House, Robbins and Metzner, 1982 'The association of social relationships and activities with mortality: prospective evidence from the Tecumseh community Health Study', American Journal of Epidemiology, 116, 123-40; Blazer, 1982 'Social support and mortality in an elderly community population' American Journal of Epidemiology 115, 684-94; Orth-Gomer and Johnson, 1987 'Social network interaction and mortality', Journal of Chronic Diseases, 40, 949-57; Welin et al, 1985 'Prospective study of social influences on mortality' The Lancet 1915-18, April 20). Referred to in *Communities, Social Capital and Public Policy: Literature Review; David Johnson, Bruce Headey and Ben Jensen; Melbourne Institute of Applied Economic and Social Research; The University of Melbourne; Melbourne Institute Working Paper No. 26/03*

²³ The Expert patient : A New Approach to Chronic Diseases Management for the 21st Century, DH, 2001, Barlow, JH et al. Self-management literature review, Psychosocial Research Centre, Coventry University, 2000 referred to in 7 op cit.

²⁴ Rushey Green, Time Bank Evaluation Report, April 1999-May 2001

*that is produced by community health projects can, in itself, be an effective preventative tool*²⁵.

In "Social Capital and Health in Camden"²⁶ Stafford and Marmot discuss the evidence that social capital is associated with a number of important health outcomes.

- Although numerous studies have demonstrated an association between social capital and health, studies have not yet been able to show causality²⁷
- Different types of social contact seem to be related to health in different ways. People who have someone to rely on for practical support tend to have better mental health.²⁸ Contact with a wide and diverse network appears to be beneficial for people's health, whereas contact within the family does not bring the same benefits²⁹. Weak ties between acquaintances and less intimate friends may be more beneficial than strong ties between family members in providing access to resources³⁰.
- American studies show that where a greater proportion of people trust each other there is lower all-cause mortality, and they view their health to be better than places where residents are less trusting. One study showed that a 10 per cent increase in the proportion of people agreeing most people can be trusted was associated with an eight per cent reduction in mortality³¹. Trust is positively correlated with participation in clubs and organisations.

²⁵ Acheson, D. Independent Inquiries into Inequalities in Health, The Stationary Office, 1998– referred to in *in vivo* cit 'Communities and individuals that are engaged in identifying and solving their own health care needs are able to overcome this sense of powerlessness at the same time as generating healthy outcomes for themselves. The social capital that is produced by community health projects can, in itself, be an effective preventative tool'

²⁶ Kahn, H & Muir, R, ed .Sticking Together, social capital and local government: the results and implications of the Camden social capital surveys 2002 and 2005, IPPR and London Borough of Camden, 2006

²⁷ (Lochner et al 2003, De Silva et al 2005). Lochner K A, Kawachi I, Brennan R T, Buka S L (2003) 'Social capital and neighbourhood mortality rates in Chicago', *Social Science and Medicine*, vol 56: 1797-1805 De Silva M J, McKenzie K, Harpham T, Huttly S R A (2005) 'Social capital and mental illness: a systematic review', *Journal of Epidemiology and Community Health*, vol 59: 619-27

²⁸ (Stansfeld and Sproston 2002). Stansfeld S and Sproston K (2002) 'Social support and networks' in Sproston S and Nazroo J (eds) *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)– Quantitative report*, Norwich: The Stationery Office

²⁹ (Stafford et al 2004). Stafford M, Bartley M, Boreham R, Thomas R, Wilkinson R, Marmot M (2004) 'Neighbourhood social cohesion and health: investigating associations and possible mechanisms' in Morgan A and Swann C (eds) *Social Capital for Health. Issues of definition, measurement and links to health*, London: Health Development Agency:111-32

³⁰ (Granovetter 1973). Granovetter MS (1973) 'The strength of weak ties', *American Journal of Sociology*, vol 78: 1360-80

³¹ (Kawachi et al 1997, 1999). Kawachi I, Kennedy B P, Glass R (1999) 'Social capital and self-rated health: a contextual analysis', *American Journal of Public Health*, vol 89: 1187-93 Kawachi I, Kennedy B P, Lochner K, Prothrow-Stith D (1997) 'Social capital, income inequality and mortality', *American Journal of Public Health*, vol 87: 149-198

- A sense of control is an important determinant of health. People who feel that they have greater control at work and family life, or report a greater general sense of control have better health³².
- People with greater financial and material resources are also more trusting, have more extensive social networks, feel in greater control over their lives, and participate in a wider variety of organisations. They tend to belong to wider social networks that are linked to better job opportunities. In this sense, social capital might reinforce social inequalities. The challenge for local government is to encourage forms of social capital that act as a bridge between social groups.

'Valuing Health' is an IDeA literature review on the health of local communities. It purports to present the beginnings of a business case for local authorities to engage in health improvement and examines seventeen thematic areas, including priority health promotion topics, eg, smoking and obesity and broader topics where local authorities' work may impact on health, eg, housing and employment. It finds the quality and extent of evidence variable; evaluations are frequently not robust; and data on costs and cost effectiveness are 'rarely collected'. However, it suggests that for local authorities focussing on the health and independence of older people presents the best potential for efficiency savings. In particular, it points to the impact of multi-factorial assessments and exercise classes on the incidence of falls and the need for care. It also promotes measures to reduce isolation / promote inclusion with the most isolated being between 1.4 and 4 times more likely to die than those who enjoy better social support.³³

Curry's literature review, 'Preventative Social Care – Is it cost-effective?',³⁴ developed as a background paper to the Wanless social care review, indicates that there is 'A paucity of quantified information about the effectiveness of preventative services'. Information about cost effectiveness tends to relate to small scale studies and is therefore not comparable.

Curry also suggests that the literature is 'very disparate in terms of content, outcomes and measurements' and that this makes pulling together and summarising findings very challenging. However, there is a 'strong financial case' for reducing hospitalisation especially through falls' reduction initiatives; and for reducing 'institutionalisation' by maintaining independence, although the 'evidence as to what is effective is rarely quantitative'. In addition, the economic benefits that might flow from upstream service developments might not be discerned for several years. She echoes Layard – concepts like happiness and independence are key to maintaining an effective health and social care system, but it is difficult to establish the cost effectiveness of services that provide

³² (Marmot et al 1997, Chandola et al 2004). Marmot M, Bosma H, Hemingway H, Brunner E, Stansfeld S (1997) 'Contribution of job control and other risk factors to social variations in coronary heart disease incidence', *The Lancet*, vol 350: 235-39 Chandola T, Kuper H, Singh-Manoux A, Bartley M, Marmot M (2004) 'The effect of control at home on CHD events in the Whitehall II study: Gender differences in psychosocial domestic pathways to social inequalities in CHD', *Social Science and Medicine*, vol 58: 1501-09

³³ Valuing Health: developing a business case for health improvement :
Final report I&DeA 2009

³⁴ Curry, N. Preventative Social Care – Is it cost effective?, background Paper to D. Wanless and J. Forder, Wanless Social Care Review, King's Fund, London, 2006

them³⁵. In a similar vein, OECD have reported that there is considerable evidence that policy instruments can improve the health of older people, but it is unclear which ones are cost effective.

But it is not all gloom! Curry also suggests, similar to 'Valuing Health', a number of approaches that are seen as cost effective, and which might be seen to fall within the 'strong community' domain (as opposed to mainstream health and care services).

- Smoking cessation and salt-reduction: Both can have a significant impact on reducing the incidence of stroke.
- Exercise: Curry refers to research by Munro et al "This particular evaluation found the scheme, with a cost of £854,700, to have the potential of preventing 76 deaths and avoiding 230 in-patient episodes, saving costs of around £601,000. Based on the assumption that life expectancy after 65 is ten years, the programme cost £330 per life saved (although the range was £100-£1,500)"³⁶
- Falls: Curry refers to the 2006 ODPM report which says: "Based on one bed day costing around £320, 196,000 bed days and the associated £63 million per year could be saved if 15 per cent of falls could be prevented"³⁷

Notwithstanding the above work LinkAge and POPP evaluations probably provide the most substantial English examples of preventative community initiatives.

The LinkAge Plus pilots³⁸ took place in eight diverse areas selected by the Department for Work and Pensions (DWP). The pilot areas were: Devon; Gateshead; Gloucestershire; Lancaster; Leeds; Nottinghamshire; Salford and Tower Hamlets. Around £10 million was invested by the DWP in LinkAge Plus over a two-year period. Pilots were given discretion, within a set of principles agreed with the DWP, over the specific nature of the activities they were to fund. The core principles of the LinkAge approach are:

- **Maximise opportunities for efficiency and capacity building.** Pilots were encouraged to look for efficiencies through joint working with partner organisations and improve outputs through capacity building.
- **Better information and access.** A 'no wrong door' approach means that older people have information on, and access to, services from an initial or single point of contact. Signposting or referral processes should ensure all relevant services are made available.
- **Wider access.** Stronger use of outreach and other approaches to enable pilots to identify and engage with isolated older people. Joined up, flexible, customer contact facilities to meet different needs, including face-to-face, visiting, telephone and electronic media.

³⁵ Layard R (2005). *Happiness: Lessons from a new science* (annexes). London: Allen Lane

³⁶ Munro, JF, Brazier JE, Davey R, Nicholl, JP. Physical activity for the over-65s: could it be a cost effective exercise for the NHS?, *Journal of Public Health Medicine*, vol 19, no 4, pp 397-402, 1997

³⁷ Making Life Better for Older People: An economic case for preventative services and activities Wetherby., ODPM, 2006

³⁸ Davis, H & and Ritters, K. LinkAge Plus national evaluation, End of project report, Department for Work and Pensions Research Report No 572, 2009

- **Engage and consult.** Older people involved in the design, delivery and development of services.
- **Better services.** Services focusing on early intervention and a preventative approach going beyond traditional health and social care functions, encouraging respect and social inclusion for older people.

A wide range of projects were developed across the 8 pilots to reflect these principles. The overall evaluation claims that LinkAge Plus is:

- Providing 'that little bit of help' which enables older people to retain choice, control and dignity in their lives;
- Starting to invert the 'triangle of care' for older people with a focus on general wellbeing rather than intensive support;
- Helping to develop services that are contributing to the improvement of older people's quality of life, healthy life expectancy and active participation.

Accounts of effectiveness / impact in LinkAge are broad-brushed and lack detail, though some local evaluations provide a sharper picture. The researchers do supply, however, an illustrative example to highlight the potential benefits in terms of cost effectiveness of a LinkAge approach³⁹. Their key findings were:

- "A holistic approach to service delivery requires some up-front investment over the two-year pilot period but quickly begins to deliver net savings, breaking even in the first year after the investment period;
- The net present value of savings up to the end of the five-year period following the investment is £1.80 per £1 invested. This is likely to be higher over a longer period;
- LinkAge Plus can facilitate services that are cost effective in their own right, including fire and crime prevention, and reduced falls associated with balance classes and home adaptations;
- Combining the costs and benefits of these services in LinkAge Plus areas with the holistic approach to service delivery increases the net present value to £2.65 per £1 invested;
- In addition to taxpayer savings there are benefits to older people monetised at £1.40 per £1 invested".

Researchers say that many of the assumptions made are conservative, and the illustrative example omits a large number of benefits that have not been quantified.

The recent national evaluation of POPP schemes provides the most robust examination of preventative approaches with older people. The Department of Health launched the Partnerships for Older People Projects programme in March 2005. The programme provided ring-fenced funding to enable Councils to establish innovative pilot projects with PCTs, the voluntary, community and independent sector. The aim of the pilots was to deliver and evaluate approaches aimed at creating a sustainable shift in resources and culture away from institutional and hospital based crisis care for older people towards earlier,

³⁹ Watt, P & Blair, I. The business case for LinkAge Plus, Department for Work and Pensions Research Report, No 573, 2009

targeted interventions for older people within their own homes and communities. Pilots were focused on delivering improved outcomes for older people in three key areas:

- Providing more low level care and support in the community to improve the health, well-being and independence of older people, preventing or delaying the need for higher intensity and more costly care.
- Reducing avoidable, emergency admissions and/or bed-days for older people.
- Supporting more older people to live at home or in supported housing such as sheltered or extra-care housing as opposed to in long-term residential care⁴⁰.

29 pilot sites established some 146 local projects of which two-thirds focused upon reducing social isolation and promoting healthy living. The other third concentrated on reducing hospital admission, or expediting discharge from institutional or hospital care. Projects were classified in three ways: in terms of needs levels addressed; whether projects were Hospital Facing or Community Facing; and project typologies (10) which were:

- Well-being– Practical
- Well-being – Emotional/Social Isolation
- Well-being – Physical
- Well-being – Community
- Information, sign-posting and access – includes advocacy
- Proactive Case Co-ordination
- Long-term conditions
- Specialist falls services
- Involving older people
- Carers services

In the national evaluation, 81% respondents agreed that improvements had been delivered in the quality of life and well-being of older people using services, and a similar proportion (78%) agreed that a greater range of services was being offered to older people as a result of POPP. Just about all POPP schemes were seen as cost effective, especially those providing practical help (98%). Practical programmes, focused on improving well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping, and exercise programmes produced best quality of life / health benefits – an average 12% increase – “as simple aids or services could affect well-being”, such as a grab-rail making washing easier, and gardening or minor repairs reducing anxiety.

An equivalent improvement was also identified following interventions providing exercise - “presumably due to increased strength and flexibility and a positive effect on mood”. Smaller improvements (4%) were found in those involved with

⁴⁰ National Evaluation of Partnerships for Older People Projects: final report, Personal Social Services Research Unit, DH, 18 January 2010

projects offering community support, proactive case co-ordination and specialist falls programmes.

An additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days. Overall, hospital overnight stays appeared to be reduced by almost half (47%) and use of Accident & Emergency departments by almost a third (29%). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Such change had a notable impact on costs with a cost reduction of £2,166 per person seemingly reported.⁴¹

“The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can ‘work’ for older people. Local authority-led partnerships, working within the context of Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed. Moreover, it has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services.

Indeed, it is possible that the evaluation results understate the benefits which can potentially be derived from such a programme. The POPP projects were, by definition, largely untested and some were necessarily more effective than others. If those seeking to introduce similar programmes were to focus on those projects that were found to be most effective and those older people found most likely to benefit from them, the returns from similar levels of investment is likely to be greater⁴².

⁴¹op cit

⁴² op cit

5 Community initiatives which are replicable, and which could make a contribution to a 'strong community'

5.1 Introduction

Where does all this evidence point to in terms of action? An authority might want to assess itself against the elements of strong community set out in Section 1, or follow the Camden approach of surveying its population about local social capital. It could then concentrate any work in areas where there are perceived deficits.⁴³

Alternatively it could focus actions where there is evidence of interventions with a social care / health pay off. Therefore, this section of the report sets out projects that are close enough to health and social care and have some demonstrable data attached to their conclusions. The final part of this section brings together some of the key features of the projects and a set of success criteria.

5.2 Older Peoples Projects –POPPS

In the last section, the POPP approach(es) was / was described, and findings from the national evaluation set out. Reference was made to a 10-fold typology of projects. The next part of this report points to illustrative projects in a number of these categories where there is evidence about effectiveness and cost-effectiveness. Authors of the POPP national evaluation honestly observe that the use of aggregate data affects how far it is possible to identify which services justify further investment (and in which combinations). For example, funding concentrated on substituting lower level prevention services for the categories of higher level services (secondary and tertiary prevention) may provide greater financial savings, but these would not meet our definition of strong community. Funding services to promote Well-being – practical, Well-being -physical health, Information and Signposting – will provide better outcomes in terms of health-related quality of life compared to higher level services, but will provide fewer immediate cost reductions. Information about the costs of specific services is not readily available, however, and local evaluations vary in the nature and quality of detail provided. Hence it is sometimes difficult to judge the relevance or otherwise of particular schemes without closer examination.

5.3 Well-being - Practical

This typology encompasses nine projects focused toward providing practical help to support the user to remain at home. The projects included small housing repairs, gardening, limited assistive technology, teleshopping and shopping, home security, and a volunteer driving scheme. Four 'handyperson' services, a teleshopping project, home security, low-level assistive technology, volunteer driver scheme and a gardening service.

⁴³ Kahn, H & Muir, R, ed .Sticking Together, social capital and local government: the results and implications of the Camden social capital surveys 2002 and 2005, IPPR and London Borough of Camden, 2006

Case study: Gardening Project (Wigan)

A suite of practical services were developed in Wigan – a handy-person project, a care and repair scheme and a Stop and Lock Project .This focuses on upgrading the security of homes by fitting items including locks, bolts and window alarms. The national evaluation highlights a gardening project – Groundwork. A 'garden squad' of local volunteers was developed to undertake basic gardening work for older people that did not require professional skills. A quote would be provided and the work then done once the amount had been agreed. Such work included lawn mowing, hedge cutting, and path clearing and lying. The scheme showed a 93% satisfaction rate with users appreciated their own facilities being improved and this was a key aspect of increasing their independence and reducing risks.

5.4 Well-being – Physical Health

This category encompassed four projects, including time-limited (e.g., eight to 12 week) exercise classes focused toward improving overall health or with some rehabilitation focus (e.g. stroke association classes); a T'ai Chi course; a chiropody service focused toward individuals within the BME community; and a rehabilitation course carried out by a voluntary organisation. Researchers calculated a 99% probability that these POPP projects are cost-effective compared with usual care.

Case Study: Exercise at Home (Camden)

The national evaluation mentions this project in Camden, provided by the Active Health Team, which provides exercise to older people with mental health needs and their carers, with the intention of increasing mobility and boosting self-confidence. Anyone over 55 years is eligible for the service, and referrals are accepted from older people themselves, their carers, and social and health care staff from either statutory or non-statutory organisations. When CSCI awarded Camden 3 stars, and 7 ratings of excellent in 2008, it specifically commended the council's work on promoting health and well-being, and this POPP project which uses older people as volunteers.

5.5 Well-being – Community

Within this typology, a mixture of projects were included ranging from direct interventions to specific localities as well as projects that set up neighbourhood schemes, strengthening and taking forward inclusive communities.

Case study: Somerset Active Living Centres (Somerset)

The POPP programme in Somerset established more than 50 very local Active Living Centres (ALCs) throughout the county, based within community centres, church and village halls. Each ALC became a 'hub' for the full range of preventive and well-being services already provided by statutory agencies and VCOs. The ALCs provided a café-style environment while hosting a variety of well-being activities, and providing information and referral to other locally available services. The ALCs were mainly supported by local volunteers, supporting a person-centred selection of services for maintaining independence, and were to serve as vehicles for community development and empowerment. Somerset report a "lessening of the effects of chronic health conditions, improved mobility, reduced social isolation and ... a renewed sense of feeling independent, in control and being a part of the local community"¹

5.6 Involving older people

These projects focused on encouraging older people to become involved with the decision-making processes, governance and evaluation of POPP services.

Case study: Expert Elders (Sheffield)

A network of older people was established as partners in the implementation of the POPP programme in Sheffield, and as decision-makers through the local strategic partnership. Expert elders were involved in service reviews, contractor evaluations, quality assurance, and the gaining of patient-user opinions on services. The network comprised over 200 people from across the City, drawn from all social backgrounds. 18% were from BME communities, 25% were carers or are cared for and over 60% were women. Participants volunteer their time but are supported by a small staffed project team. Expert Elders receive support and training to help them develop their skills and confidence, so they can influence the development and planning of services and are given information about how Sheffield's statutory and voluntary agencies work. The network meets every 6 weeks. It is claimed that services have changed as a result of Expert Elders, for example:

- Generic care workers are now being trained in hand and toe nail cutting after a network member complained that his home carer could not cut his toe nails. This initiative is known as 'Joe's Toes'.
- The job descriptions for Rapid Response nurses were changed to include mental health skills as older people felt that 'ordinary' intermediate care services did not recognise the number of older people with mental health needs.
- Expert Elders have worked with the City Council and Brunel University on the DIADDEM project (Delivering Inclusive Access for Disabled or Elderly Members of the community) which aims to make online forms easier to complete¹.

5.7 Older peoples projects- LinkAge

In the previous section of the report the LinkAge approach, and information about its effectiveness and cost-effectiveness were set out in some detail. A

wide range of projects were developed across the 8 pilots to reflect LinkAge principles. Some examples are:

- **Efficiency / capacity building** – a single point of access (first Contact) in Nottinghamshire with net present value over 5 years of £1.80 for every £1 spent; single access gateway in Tower Hamlets; training and skill development in the third sector (Leeds)
- **Engage and Consult** - a Senior Council in Devon; an Older Persons' assembly in Gateshead; Salford's older people fora; use of older people as researchers in Nottinghamshire
- **Better services, to promote improved well-being and independence** – including TimeBanks in Lancaster and Gateshead; an employment service in Lancaster with potential savings of £370,000; a small tasks and repairs project in Gateshead, and various exercise related schemes such as Activity Friends in Nottinghamshire and Hips and Heart groups in Salford. The researchers estimate that each £1 spent on balance classes can, in reducing falls, result in health and social care savings of £1.40, plus a benefit to individuals of £0.90 from improved quality of life.
- **Better Information and Access** – the AskSid website in Salford; a one-door model in Devon; Village Agents in Gloucestershire (detailed below); Outreach advisers in Nottinghamshire for the isolated / excluded; a 'proactive information network' in Gateshead; care navigators in Lancaster.

Most of the LinkAge Plus Pilots – and many POPP pilots - developed different approaches to supplying information for older people. However, as Godfrey and Denby recognise there is more to giving information than handing out leaflets.

"Information provision needs to be pro-active, multi-faceted and wide ranging, unbounded by the interests of agencies and services; accessible through trusted sources; and of a quality to enable people make choices". "Publicising information so that it is widely accessible, including to those who are restricted to their own homes requires both use of a range of media as well acknowledging that 'trusted sources' are multiple and varied"⁴⁴. Some projects have encountered real difficulties in ensuring that information is updated and available, however (such as the Kent Invoke project).

The Gloucestershire Village Agent Scheme makes use of local older people as sources of information for local citizens⁴⁵. Village Agents bridge the gap between communities and organisations that are able to offer help or support. Apart from providing high quality information, they put people in direct contact with the agencies that are able to provide the service they need, carry out a series of practical checks, and contribute to the building of communities.

In Gloucestershire over 31,000 contacts were made to Village Agents at a cost of £10 per contact. The contacts were primarily made at existing meetings although increasingly at home and through other stakeholders. The referrals raised by these contacts included benefits, fire safety, transport and a range of

⁴⁴ Godfrey, M. and Denby, T. Literature Review, Older People Accessing Information and ICTs, Centre for Health and Social Care, Leeds Institute of Health Sciences, University of Leeds, March 2007

⁴⁵ The POPP scheme in Dorset has wayfinders who fulfil a similar role

other concerns. An additional benefit is that older people have increased confidence in contacting statutory agencies as a result of this scheme.

It is an approach particularly well-suited to rural communities, and reflects the assumption that 'older people are more likely to source information and access services from someone they know and trust, thereby promoting and supporting longer term independence'. 83% people say they are happy to approach someone they know and trust in the community for health and advice. Identified benefits include a variety of efficiencies for partner agencies, such as:

- Agents refer people to services they would not have the resources to find due to their rural location. This is especially important to services such as the Fire Service who have lower response times in rural areas. Therefore finding customers at risk and fitting smoke alarms is vitally important. Agents make 150 smoke alarm referrals each year; given that each domestic fire costs £24,900 it is reasoned that agents make a tangible contribution to fire safety.
- During the pilot Village Agents were responsible for an extra £6015 in benefits uptake per week.
- Agents visit people in their homes and recommend falls prevention measures. During 2007 there were 148 referrals for occupational therapy; many of these were for aids such as grab rails to prevent falls. There were also 93 direct referrals to the Home Improvement Agency for minor works. Agents set up 8 Tai Chi groups which had an average of 104 attendees each week.

The range of projects supported by POPP and LinkAge offer two broad choices. Firstly, to identify which specific projects might usefully fill gaps in the county's own current profile of offerings. Secondly, many areas have successfully combined a number of projects under the POPP / LINKAGE banners. That has optimised use of resources, and established a local brand that has resonance with older people. Taken as a whole, the ethos of 'strong community' becomes more apparent.

Outside of LinkAge and POPP, there are three types of project with positive track-records that are particularly worthy of consideration:

- TimeBanks
- Expert Patient Programmes
- Key Ring

Each of these is discussed below.

5.8 Time Banks

A Time Bank⁴⁶ is a form of community currency that rewards informal volunteering by paying one 'hour' for each hour of commitment, which can at any time be 'cashed in' by requesting an hour of work in return from the system. In most Time Banks, a broker is employed to manage the scheme, maintain a

⁴⁶ Seyfang, G. Time Banks: Rewarding community self-help in the inner city?. Community Development Journal, 39 (1): 69, 2004

database of participants, and recruit people and organisations, and a system is developed to record, store, and reward transactions when neighbours help neighbours⁴⁷.

Time Banking is a tool that is being used in many different ways to assist statutory agencies to achieve their goals and at the same time to improve social outcomes for local people. Its brochure points out that there are only two constants:

- The sharing of skills and knowledge is rewarded by a local currency based on time and one hour's engagement always earns one time credit. There is no pricing system so everyone's skills are valued equally.
- Everyone signs up to share a set of core values:
 - Recognising people as assets - people are the real wealth of a society
 - Valuing work differently - unpaid work such as caring is priceless
 - Promoting reciprocity - giving and receiving builds trust and mutual respect
 - Building social networks - relationships are the crux of people's well being

There are three broad models for Time Banks:

- **Person-to-Person model** - exchanges between individuals
- **Person-to-Agency model** - where service users or local communities act as agents to help an organisation to realise its goals and are rewarded with time credits
- **Agency to Agency model** - in which organisations are using time credits as a medium of exchange to share skills and resources with each other

Time Banks originated in the USA but are developing at some pace in the UK, most locally in Gloucestershire. They show positive results in terms of improved self worth, and reduced depression⁴⁸. They characteristically attract groups that are normally socially excluded, and helpfully blur the distinction between givers and receivers⁴⁹. They help with creating social networks that produce healthy outcomes. There is evidence of reduced hospital emergency admissions⁵⁰. These are low cost and hence cost effective schemes which – brokers apart – tend to rely on volunteers with time being used as the operational capital.

5.9 Expert Patient Programmes

Launched by the Department of Health in 2001, the Expert Patient Programme is a peer-led self care support programme for people living with any long term

⁴⁷

http://www.timebanking.org/documents/Publications/Timebanking_Prospectus.pdf

⁴⁸ Rogers, B & Robinson, E. The Benefits of Community Engagement: A review of the evidence, IPPR, Home Office, 2004

⁴⁹ Rushey Green Time Bank Evaluation Report April 1999-May 2001

⁵⁰ op cit

condition, their carer and families. Originating at Stanford University, some of the courses are delivered by lay people, some are delivered by a mix of health specialists and lay people. The courses are attended by between 8 and 12 people and last between 6 and 8 weeks depending on the needs of the groups.

The National Evaluation of self care programmes, undertaken by the National Primary Care Research and Development Centre on behalf of DH, published its final report in December 2006. Although it could not prove absolutely the effectiveness of such programmes, but it made clear that people benefited from self management education, not only by improving their knowledge but in sharing their experiences and learning with other people in similar circumstances. This was quantified as one extra week of 'perfect' health per year for those on the EPP course. People who attend courses have improved self confidence and are more able to deal with impact of long term illness on their lives. It would also appear that the more people who manage their own conditions, leads to less demand on NHS services. Patients can also become active in building patient communities based on mutual aid.⁵¹

In terms of cost effectiveness, the evaluation concluded that such intervention "is very likely to provide a cost effective alternative to usual care in people with long-term conditions". In a research trial, the intervention group was associated with better patient outcomes, at slightly lower cost – over a six-month period, the mean costs per patient in the programme were £1,912 compared with £1,939 in the control group, a saving of £27.

5.10 KeyRing

KeyRing - Living Support Networks (LSN) are networks of people who need some support to live safe and fulfilling lives in the community. Initially KeyRing focused on adults with learning disabilities, but since 2006, membership has extended to other client groups. It now has over 100 networks in the UK, with almost 900 Network members, in 54 separate local authority areas. The networks operate as a form of community co-production, whereby users offer each other mutual support and the KeyRing volunteers and liaison staff support people to make connections in their own community. The service users become stronger and more independent, need less support from staff and feel better about themselves and their future.

The organisations running KeyRing charge relatively little – around £4,000-£4,800 per user per year, compared to costs of up to £40,000 p.a. in residential care (where many individuals would otherwise be)⁵².

CSED felt LSNs were potentially very cost effective as they make use of the time and skills of a volunteer and of individual members rather than being overly reliant on expensive professional staff; promote access to universal services rather than costly specialist day services; and facilitate skill and confidence in members by encouraging them to do things for themselves rather than be

⁵¹ National evaluation of the pilot phase of the Expert Patients Programme - final report, National Primary Care Research and Development Centre, 1 December 2006

⁵² Poll, C. Co-production in supported housing: KeyRing living support networks and neighbourhood networks', Research Highlights in Social Work: Co-Production and Personalisation in Social Care Changing Relationships in the Provision of Social Care, 49: 49-66, 2007

www.keyring.org

dependent on support. Often this leads to additional (to KeyRing) specialist support being reduced/ withdrawn.

Typically, a network has ten people. They live in properties (from all types of tenure) in a defined geographic area. People with support needs occupy nine properties and a Community Living Volunteer (CLV) lives rent-free in the tenth. The CLV provides at least 12 hours of their time each week to:

- Support the members flexibly,
- Facilitate members to support each other, using their particular skills, and
- Build links with neighbours, community organisations etc. such as CAB, police, etc.

A Supported Living Manager (SLM) supports each CLV. The SLM manages a cluster of networks. Members also have direct support from the SLM (when needed) and access to the KeyRing "Out of Hours" service. Some LSNs also have a paid community support worker who provides more intensive 'floating' support to members who need it⁵³.

LSNs can enable people who have enjoyed high levels of family or paid carer support to gradually move to living independently in the community. "The fact that none of the people from previously very supportive environments had lost their tenancy nor experienced homelessness during their time with KeyRing (17 years was the longest case) demonstrated how effectively LSNs can sustain people with support needs to live independently"⁵⁴.

Reproduced from the CSED evaluation, the table below proposes the cost-effectiveness of the LSN approach. This conclusion has been drawn on the basis that the network substituted for alternative forms of support that would have cost more e.g. floating support and day care.

Network	Number of Current FTE Members²	Annual Cost of the Network	Savings on alternative support	Net Saving/ (Cost)
Inner City	9	£30,630 ³	£47,590	£16,960
Market Town	9	£38,090	£55,430	£17,340
Rural	7.5	£41,200	£42,945 ⁴	£1,745
Total	25.5	£109,920	£145,965	£36,045
Ave per fte Member	n/a	£4,310	£5,724	£1,414
Adjusted averages⁵ per fte Member	n/a	£4,233	£5,724	£1,491

CSED's study⁵⁵ concluded: "LSNs are a simple idea and are fully consistent with "Valuing People Now" and "Putting People First". They do appear to be able to:

⁵³ KeyRing, Living Support Networks CSED Case Study, November 2009

⁵⁴ op cit

⁵⁵ op cit

- Help adults with support needs to achieve more than traditional forms of support.
- Be cost effective, as the costs of a network are, over time, more than offset by reductions in other forms of support as members become more self-sufficient.

Living Support Networks has been included in this review because, at present, relatively few networks exist although potentially many thousands of people could contribute to and benefit from being members, of them i.e. there is significant potential to expand the use of LSNs where commissioning processes identify they could be cost effective”.

5.11 Bringing the information together.

Taking the five key project areas and rating each of the projects against the features of a 'strong community' highlighted in Section 3 produces the following picture.

Feature	POPP	LinkAge	TimeBanking	Expert Patients	KeyRing
Empowerment	✓	✓	✓	✓	✓
Supporting networks & Neighbourliness	✓	✓	✓	✓	✓
Reciprocity	✓	✓	✓	✓	✓
Collective norms and values	✓	✓	✓	✓	✓
Belonging	✓	✓	✓	✓	✓
A community that prevents...	✓	✓	✓	✓	✓
Citizenship, Participation and engagement ⁵⁶	✓	✓	✓		✓
Volunteerism & Altruism	✓	✓	✓		✓
Good information flows	✓	✓		✓	✓
A community that supports non-institutional	✓	✓		✓	✓
Trust			✓	✓	✓
Associational	✓	✓			✓

Feature	POPP	LinkAge	TimeBanking	Expert Patients	KeyRing
activity					
Safety	✓				✓
A community that re-ables....			✓	✓	
	12	11	10	10	13

In terms of intensity of involvement of the respective projects then this crude scoring suggests that KeyRing comes out as the most intensive, TimeBank and Expert Patient as the least. With LinkAge and POPP it probably depends on the particular scheme.

This 'feels' the right order given that KeyRing is supplying alternatives to residential care on occasions, dealing with issues of considerable risk, whereas the Expert Patients programme is much less linked to avoiding a reasonably immediate high intensity outcome.

6 Potential ways forward

None of the schemes are 'magic bullets'. No simple model can be transposed without matching it to the local environment.

Section 3 proposed a definition of 'Strong Community', and the various elements through which such communities could be identified / developed.

Section 5 considered the broader POPP and LinkAge programmes, and specific initiatives within them; and three other highly successful schemes which may be of value within the county.

Taking each of the projects in the preceding section the Table below outlines the key criteria projects identified as contributing to their success.

POPP	LinkAge	TimeBanking	Expert Patients	KeyRing
The involvement of older people, voluntarism	Engagement and consultation, voluntarism	Involvement, participation, voluntarism	Involvement, participation, voluntarism	Involvement, participation, voluntarism
Whole system working	Joint working	Links to other community organisations		Co-ordinates support from a range of sources
Small services providing practical help and emotional support	Focus on popular, low-cost interventions			
Involvement of the NHS, including GPs	Commitment/buy-in from partners		Buy-in from NHS	Ownership by users
Leadership, particularly from older people	Being user led Effective leadership and management	Control Leadership from the broker	Patient in the driving seat Peer led Empowerment	User control Enablement
An early emphasis on sustainability	Emphasis on measurement and evaluation, linked to sustainability			
	Better information and access			
		Reciprocity	Mutual aid	Mutual support and co-production
Adapted to local circumstances	Adapted to local circumstances	A strong local presence Adapted to local		Strong connections to neighbourhoods

POPP	LinkAge	TimeBanking	Expert Patients	KeyRing
		circumstances		
		Good communication	Communication Active and effective promotion of benefits	
		Cohesiveness of the group	Motivation	
				Trust

Although, as identified earlier, some of the evaluations are a little thin on detail overall the following factors look to be important in delivering strong community' projects.

Local - Successful schemes are usually adapted to take account of local needs, circumstances and resources – rather than imported piecemeal from outside of the community. They give attention to establishing strong roots in local neighbourhoods.

Reciprocity and mutual support - People provide a level of care for each other; the individual provides a service to others, or acts for the benefit of others at a personal cost, but in the general expectation that this kindness will be returned at some undefined time in the future in case of need; or individuals work to co-produce relevant services.

Voluntarism – The willingness of people to work on behalf of others without the expectation of pay - is a feature of all these schemes, though how big a feature may vary.

Sustainability – Successful projects give early attention to how they might be supported in the longer term, or for as long as they need to be in place. Part of this is about ensuring involvement and ownership/ buy-in; part of it is about monitoring and evaluating the schemes carefully so benefits can be actively and positively promoted.

Whole system working – schemes promote and rely upon joint working, gaining the involvement and commitment of partners – often the NHS. But there is a wider sense of taking a big picture view across a range of different interests, identifying the various components of the whole system, understanding the relationship between each of these, and recognising the benefits and risks that come within that whole system (such as opportunities to share costs), balanced against knowing how the failure of one part can affect another).

Leadership – leadership is seen as important in all schemes. This might be about ensuring that the user is in the 'driving seat', or that where there are staff – as with TimeBank brokers or KeyRing Community Living Volunteers – they are effective in enlisting and co-ordinating the aid and support of others in the accomplishment of common tasks.

An outcomes focus – Projects that are most successful have a set of clear, proscribed, achievable goals, preferably starting from an evidenced basis as to

why they might work. Conversely, failing projects often have a lack of clarity over what they are trying to achieve or a weak evidence base.

IPC would also add in that from a health and social care perspective success would also mean projects that at least increase peoples independence and at best are restorative, the former being an underpinning of many of the projects described in Section 5.

These characteristics can be distilled into the following framework against which new or existing projects could be tested.

Fig 1 A potential funding framework for community initiatives.



Appendix A

CIRCLES OF SUPPORT

Introduction to the model

The Circles of Support approach is a tool which can be used to enable older people to rediscover and reconnect with ordinary life, and more importantly engage in mainstream social activities.

This model provides a way of working with older people and is not a stand-alone service. It relies on trained staff to have more focused conversations about.

- What people would like to do or have in their lives.
- Working out with them how to achieve new aspirations.
- Using and expanding networks ‘‘Circles’’ to achieve aspirations.

Background

Typically older people are referred to Social and Community Day Centres at a point of crisis in their lives i.e. bereavement, health deterioration etc and where they are often referred to as being socially isolated and in need of support.

Opportunities for other social activities have not always been considered.

The Project Aims:

- To find out what people would like to do, either as an alternative to day care, or in terms of how else the day care resource might be used.
- Introduce older people to the idea of trying more main stream activities.
- Highlight issues about how alternatives to day care might be supported.

Addressing Other Considerations

- Transportation.
- Cost of activities.
- No one to go with.
- Unsure about accessibility.

Limitations

- Client selection.- Consideration needs to be given to the criteria for selecting clients for ‘‘Circles groups’’ particularly if the overall aim is working towards older people independently accessing services. This then will exclude certain people i.e. clients with dementia, high level care needs, and highlights the importance of home assessment visits.

New Circles in the County

Working with small groups of people (maximum of eight) to encourage them to research information about local groups and offer advice and support to use any chosen services. Over ten weeks there would be six meetings with the group when they will have opportunities to discuss interests and to see what is available to them locally. There would be a follow up session four weeks after the last group session to evaluate and to check whether people had engaged with their chosen activities. Although Circles of Support are time limited groups, where people are clearly needing more support, there could be the opportunity to join with another Circle at a later time.

We will start a Circles of Support with a minimum of five people and welcome referrals.

Further Information on Social Capital in Camden

In 2002 and 2005, Camden commissioned two surveys aimed at measuring social capital in the borough (Office for Public Management 2002 and 2005). The approach was described and debated in:

Sticking together: Social capital and local government: The results and implications of the Camden social capital surveys 2002 and 2005
Edited by Halima Khan and Rick Muir © ippr and London Borough of Camden 2006

This publication was intended to help Camden explore the significance of survey findings and develop policies in response to them. The various quotes set out below are taken from this publication.

A third survey was undertaken in 2008, and details can be found in:

Understanding Social Capital in Camden: Findings from the 2008 Social Capital Survey Ipsos Mori 2008 – 3rd survey

The work is also referred to in:

Co-production, social capital and service effectiveness, Jude Cummins and Clive Miller, OPM October 2007

Both the 2002 and 2005 Camden social capital surveys consisted of two attitudinal surveys of adult residents in Camden. The first was a borough-wide survey of 1,000 randomly chosen residents, while the second was a survey of 100 residents living in each of Camden's ten neighbourhood renewal areas.

"Camden was something of a vanguard among local authorities – and, to a large extent, still is".

While the concept of social capital was beginning to appear in some national surveys, there was no agreed way of measuring it. OPM drew on a number of sources to develop their model, in particular Onyx and Bullen's component analysis which uses the four components of participation, reciprocity (or altruism), trust and sociability as a basis for developing indicators⁵⁷.

The OPM questionnaire used a range of proxies for different elements of social capital (such as membership of different groups and actions taken to solve local problems during the past year) alongside "questions about various aspects of people's lives and feelings (such as favours done for, and by, neighbours; trust in various public institutions; and people's views as to what it is like to live in their local area). In devising the measurements, it was also important to bear in mind what Camden Council and its partners were able to do to influence improvements in the various elements of social capital. Otherwise, there was a danger that this would simply become an interesting and costly exercise in measurement that would be of no practical use".

⁵⁷ Onyx, J and Bullen, P (2000) 'Sources of social capital' in Pascal C, Bertram T, Gasper M, Mould C, Ramsden F, and Saunders M (2000) *Research to inform the early excellencecentre's pilot program*, Worcester: Centre for Research in Early Childhood

During the last decade the concept of social capital gained much greater currency in the UK, and it was increasingly being researched through national surveys. In particular, the Office for National Statistics analysed 15 government and non-government surveys and mapped the various measures of social capital onto a matrix of different components. This allowed OPM to compare what was being used elsewhere, and to establish national comparisons with the Camden results. The methodology was adjusted to take account of broader learning about the social capital concept between each survey.

In 2002, OPM designed and ran a series of social capital workshops in each of the borough's neighbourhood renewal areas to help Camden interpret the results of its survey. These were facilitated by community development staff, alongside groups of local residents." We devised a model of a strong community that enabled us to explain the concept of social capital – first, by getting participants to map the more easily recognisable physical assets in the community (shown on the left-hand column of the model), and then, by asking them to map the softer aspects relating to social capital. Rather than using specialist terms and jargon, such as 'community cohesion' and 'reciprocity', we used phrases such as 'living together', 'respect' and 'neighbourliness', which were more easily understood and discussed by local residents".



The social capital workshops informed understanding about levels of social capital in individual neighbourhoods. In particular, they were very helpful in understanding weaknesses and developing ideas about how to build social capital in particular parts of the authority. Specific suggestions included turning a fenced-off park into a place for young people, and strengthening a local tenants association. Attending the workshops themselves encouraged people to make a contribution.

Camden, reflecting on their approach, refer to:

- *"the importance of breaking down the concept of 'social capital' into issues and language that people can readily understand;*
- *the difficulties inherent in attributing any changes in social capital to changes in policies, practices or services provided by public sector*

agencies, and the importance of building in clues during both the design and analysis stages to help with this attribution;

- *the importance of measuring both bonding and bridging social capital⁵⁸;*
- *the availability of national comparators to aid interpretation of local results (nb - the 'Place' survey does this now, to some degree); and the value of carrying out qualitative work both to aid the interpretation and usefulness of the survey data, and as a means in itself of building social capital".*

⁵⁸ Different types of social capital can be described in terms of different types of networks:

Bonding social capital describes closer connections between people and is characterised by strong bonds, e.g. among family members or close friends – it is good for 'getting by' in life. This is particularly important in the promotion of good health.

Bridging social capital describes more distant connections between people and is characterised by weaker but more cross-cutting ties, e.g. with business associates, acquaintances, friends of friends – it is good for 'getting ahead' in life

Linking social capital describes connections with people in positions of power and is characterised by relations between those in a hierarchy where there are differing levels of power – it is good for accessing support from formal institutions.

Appendix C

Further Information on the Expert Elders Scheme, Sheffield⁵⁹

The expert elders use their experience and views to improve services and the quality of life for older people in Sheffield. The target for the first year of the network being established was 90 older people. This target was achieved in just the first six months of the programme. The network is now made up of over 200 people from across the city drawn from all social backgrounds and representing the diversity of the city. 18% are from BME communities, 25% are carers or are cared for and over 60% are women. They volunteer their time and use their experience and views to improve services and the quality of life for older people in the city. Over 140 organisations have requested Expert Elder involvement in their development plans.

There are two Expert Elder Network Coordinators, whose role is to identify older people willing to become elder experts. They make sure that older people from groups that are traditionally harder to reach and are under represented are encouraged to get involved. They provide Expert Elders with support and training to help them develop their skills and confidence, so they can influence the development and planning of services.

The funding for the initial phase of the project (POPP) has now come to an end. Some transitional funds have been made available until March 2010. Sheffield City Council has agreed to pick up funding. Expert Elders are now moving on to a new phase. This requires:

- Streamlining expectations and getting best use from shrinking resources.
- Finding a host network/organisation to provide arms length management, in order to make sure the Expert Elders network continues to develop its role as 'critical friend'.
- Increasing the role of the Expert Elders in building the membership of the network.⁶⁰

⁵⁹ Much of this material is based on [Operational framework for the involvement and engagement of older people in Sheffield \(PDF, 332kb\)](#) This document gives details of how the Expert Elders Network operates and information about how people can join it. We are still trying to obtain information about funding from Sheffield which if successful we will forward to the County.

⁶⁰ Expert Elders: More than Just a Tickbox National Empowerment Partnership brochure available at http://www.yhep.org.uk/sites/default/files/resources/VOICES%20Older%20People%20Web_0.pdf